

not morally obligatory. Even if it were, it is not our job as doctors to keep our patients up to the moral mark.

A non-coercive, non-judgmental policy reflects and shows our proper primary moral commitment as doctors to the interests of our current patients. But I believe that it is also the policy that best promotes the advancement of medical science. Overall we are likely to recruit far fewer research subjects by moral arm twisting than if we ask our patients nicely, pointing out the great benefits of their participation in clinical trials but gracefully accepting any refusals.

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## Circumcision and uncircumcision

EDITOR,—I wish to respond to Roger S Kirby's review of my book.<sup>1</sup> Kirby expresses doubt that the reception of sexual stimuli is affected by circumcision. While the current effort to research that question directly is still in preliminary stages, Ritter has discussed at length the various ways in which circumcision interferes with the sexual function of the penis—including the consequences to the glans itself.<sup>2</sup>

Kirby makes no distinction between surgical and non-surgical restoration procedures when he warns of "considerable risks." While surgical restoration entails all the usual surgical risks, such risks are not encountered with non-surgical methods. I am in contact with hundreds (if not thousands) of men who are restoring their foreskin by a variety of non-surgical methods. I know of no case of injury beyond minor abrasions when tape has been removed too vigorously.

Finally, as a psychologist, I am aware of the placebo effect, which Kirby suspects may be the cause of the reported gains in the sensual sensitivity of the glans. I now know dozens of men who have had a re-covered glans for several years. If their enhanced sexual sensations are simply a placebo effect the consequences of this particular placebo are long term and stable.

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1 Kirby RS. The joy of uncircumcising! Restore your birthright and maximize sexual pleasure [book review]. *BMJ* 1994;309:679. (10 September.)

2 Ritter TJ. *Say no to circumcision!* Aptos, CA: Hourglass Book Publishing, 1992.

## Assisted suicide for depression

EDITOR,—It is important to learn the appropriate lesson from Alan D Ogilvie and S G Potts's editorial concerning Dr Boudewijn Chabot's assistance in the suicide of a depressed patient.<sup>1</sup> Euthanasia can be compared to psychosurgery, since it is an inherently destructive medical intervention that is always regrettable and, while occasionally warranted, is potentially open to abuse. As with psychosurgery,<sup>2</sup> restrictive legislation should specify caution to ensure sufficient consultation to provide adequate safeguards.<sup>3</sup>

The disquiet raised by the Chabot case is not over the fact that the patient's suffering was psychological rather than physical (all suffering is psychological); it is because it was not clearly established that the suffering could not be relieved. There was presumably no great urgency for Dr Chabot to act as his patient was not critically ill. If

he had been required to refer his patient to a tribunal for a formal second opinion before he intervened the treatment options would have been thoroughly reviewed. A tribunal would be most unlikely to recommend euthanasia (or assisted suicide) before a trial of drug treatment, and probably electroconvulsive therapy, had been shown not to produce any change in the patient's wish to die.

The fantasy of a slippery slope is born not of reason but of a dismissive contempt for the moral sensibilities of the majority of the population—that is, for common sense. It is unfortunate that the House of Lords select committee did not avail itself of the recent opportunity to place the law on a more rational and coherent footing. As Smith noted, however, "the tide seems to be running for euthanasia."<sup>4</sup> The slippery slope is submerging, and Lord Walton's sandcastle will not prevail for long.

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1 Ogilvie AD, Potts SG. Assisted suicide for depression: the slippery slope in action? *BMJ* 1994;309:492-3. (20-27 August.)

2 *Mental Health Act 1983*. London: HMSO, 1983: section 57.

3 Helme TM. "A special defence": a psychiatric approach to formalising euthanasia. *Br J Psychiatry* 1993;163:456-66.

4 Smith R. Euthanasia: time for a royal commission. *BMJ* 1992;305:728-9.

## Payment proposed for blood donations in Germany

EDITOR,—During a recent meeting of the International Society of Blood Transfusion in Amsterdam, F von Auer, of the Federal Ministry of Health in Germany, issued a formal statement, which signalled that the German government, in an attempt to address the challenge of self sufficiency in blood and blood products, planned to introduce a system of payment for all blood donors and that the reimbursement would be DM 50 (£20) per donation. This would be a serious breach of the European Union directive 89/381. Of more immediate concern, however, is that it could represent the beginning of a movement in Europe leading unequivocally to a deliberate and unnecessary diminution in the safety of blood and blood components.

I hope that colleagues in Germany will advise their ministers of the gravity of this retrograde development for it not only will have an impact on the safety of blood in Germany but may, long term, add appreciable restrictions to the movement of blood and blood components throughout Europe. It will also almost certainly lead to a disruption of the Euroblood programme—whereby some European blood transfusion services support deficiencies of supply in the United States—for the Federal Drug Agency is unlikely to permit the movement of blood and blood components from paid blood donors into the United States.

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## Rebuilding health services in Rwanda

EDITOR,—African Rights' report of the massacres in Rwanda makes sombre reading.<sup>1,2</sup> The fact that doctors and other health workers were involved in the genocide, either willingly or after they and their families had been threatened with immediate death, is well documented. One of the effects of this is only now becoming clear: a whole layer of primary health care workers has all but dis-

appeared. The more senior they were the more likely they were to have been implicated in the massacres (or killed for refusing to take part). Many health workers who were not involved are unable to return from Zaire, where the Hutu militias are openly active and still use appalling brutality to intimidate their "own" people to prevent them returning to Rwanda. The destruction and looting of health facilities have been almost universal but are far easier to remedy than the effects of this extensive and selective loss of key health workers.

Save the Children Fund is working closely with the new government to help rebuild primary health care services in the prefecture of Ruhengeri. Here, typically, two thirds of all health centre staff are missing, being either dead or in the camps in Zaire. The fact that the remaining staff are predominantly from the most junior grades has major implications for this reconstruction of services. The staff must be encouraged and their training needs sensitively assessed. In the short to medium term, new supplies of equipment and drugs, for example, must match the staff's training and abilities. In a population as traumatised as this, where virtually everyone is shocked and grieving, any such assessment must be performed delicately.

The community's confidence in health workers has been gravely shaken. Village meetings, the reforming of health centre committees, and community diagnosis are proving useful in rebuilding trust. The future is uncertain; despite threats from the militias and ousted officials to invade from Zaire the new government in Rwanda has made a brave start but needs support. So do health workers at village level.

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1 African Rights. *Rwanda: death, despair and defiance*. London: African Rights, 1994.

2 Dillner L. Human rights group condemns UN in Rwanda. *BMJ* 1994;309:895. (8 October.)

## Influence of patients' expectations on disease

EDITOR,—Michael Loudon continues the debate about the contribution of psychological factors to the development of the chronic fatigue syndrome and the influence of patients' expectations on the prognosis.<sup>1</sup>

I developed glandular fever over a year ago. For three months earlier this year I had considerable but variable difficulty in getting out of bed in the morning, muscle "woodenness" all over, and wobbly legs in association with a still positive Paul-Bunnell test. Normal activities have not been a problem for some time now, but I am still struggling to resume sporting activities at something like my previous level.

Why do we seek to make general statements? It is so easy to illustrate the futility of trying to generalise. For example, the teenage son of one of my colleagues on the nursing staff at our hospice died of hepatitis arising from the early stages of glandular fever, despite his transfer to a liver unit. By contrast, I had a normal appetite from the beginning of my illness and no abdominal tenderness. If this lad died of hepatitis and I had no hepatitis at all, does anyone suggest that he did not have a helpful attitude to his illness, while I did to mine? I think not. Why not? Because when we understand and can measure we accept that there is a range of organically based illness.

Surely the reason why there is scepticism about whether the chronic fatigue syndrome has an organic basis is because of the implications for long term absenteeism from work as well as the cost to the country in benefits. These are hardly consider-

ations that should feature in the reckoning of a profession that regards itself as having a scientific basis. Perhaps we should remember that always and never are words that we contemplate at our peril in medical debate, even if explanation eludes us.

Incidentally, with reference to Loudon's article, the only person who offered a guess as to how long I might have difficulties was a retired general practitioner with a lifetime of community experience behind him.

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1 Loudon M. Great expectations. *BMJ* 1994;309:676. (10 September.)

## Controlled trials of dental amalgam are needed

EDITOR,—The response of almost every writer from the dental profession to the suggestion that dental amalgam is hazardous to health is that adopted by Ivar A Mjör: to sit back and challenge the opponents of amalgam to produce proof of harm.<sup>1</sup> Not only is this notoriously difficult to do, as in all cases of chronic low level toxicity, but it is fundamentally the wrong approach. The initial question is not a scientific one at all but a question of the burden of proof.

With any procedure that may be hazardous the onus of proof must shift. It is up to the advocates of that procedure to show its safety, not for its opponents to prove damage. The charge against the dental profession is that this has never satisfactorily been done. It is not enough to rely on comparisons with staff who handle mercury, but who absorb it in different ways from dental patients; on theoretical considerations of dose; or on a hundred or more years of use (what about smoking?). Contact hypersensitivity is not the issue here. Nothing less than long term population studies with proper controls, in the best traditions of rigorous research, will suffice in a case of such potential seriousness. These have not been done.

The dental profession should get its house in order with regard to research; above all, attention should be paid to the key question of the burden of proof in medical as well as environmental matters of this kind.

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1 Mjör IA. Side effects of dental materials. *BMJ* 1994;309:621-2. (10 September.)

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## Use of complementary therapies

EDITOR,—Peter Fisher and Adam Ward report high use of complementary therapies throughout Europe.<sup>1</sup> The figures for the United Kingdom are based on surveys of public opinion carried out by organisations such as the Market and Opinion Research Institute and Gallup. As the authors admit, such data should be interpreted with caution. With a view to overcoming some of the shortfalls of these studies the Research Council for Complementary Medicine recently commissioned a methodological pilot study for a population based survey of the use of complementary medicine (unpublished report); this was conducted by Kate Thomas and colleagues at the University of Sheffield.

Postal questionnaires were sent to 921 adults sampled from electoral registers. Subjects were asked whether they had consulted a practitioner of six named therapies or any "other specialist in complementary medicine" in the past 12 months. The six named therapies were acupuncture, chiropractic, osteopathy, homoeopathy, herbal medicine, and hypnotherapy. A 78% response rate was obtained (718 subjects).

The crude estimate of use of the six named therapies in the previous 12 months was 8.5% (95% confidence interval 6.7% to 10.9%), with lifetime use estimated at 16.9% (14.3% to 19.9%). Use of other complementary therapies (for example, spiritual healing and aromatherapy) was estimated at 2% a year. A quarter of the sample had purchased over the counter homoeopathic or herbal remedies at least once. Roughly two thirds of these people had never visited a practitioner, giving an estimate for lifetime use of some form of complementary medicine of 33%. These preliminary data broadly support the figures given by Fisher and Ward. Use among certain groups of patients was higher. It has been reported that 46% of children with cancer,<sup>2</sup> 66% of patients with rheumatoid arthritis,<sup>3</sup> and 40% of patients with HIV infection and AIDS<sup>4</sup> have used complementary therapies.

Given this degree of use of complementary medicine and that such therapies may affect health status, doctors should routinely include questions about complementary therapies in history taking. There is strong evidence that patients do not readily volunteer this information, possibly for fear of admonishment.<sup>2</sup> In addition, use of complementary medicine may be a confounding factor in clinical trials, especially as many trials study the groups of patients most likely to use complementary medicine. Documentation of such use should therefore become a routine measure in assessments of outcome in clinical trials.

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- 1 Fisher P, Ward A. Complementary medicine in Europe. *BMJ* 1994;309:107-11. (9 July.)
- 2 Sawyer MG, Gannoni AF, Toogood IR, Antoniou G, Rice M. The use of alternative therapies by children with cancer. *Med J Aust* 1994;160:320-2.
- 3 Boisset M, Fitzcharles MA. Alternative medicine use by rheumatology patients in a universal health care setting. *J Rheumatol* 1994;21:148-52.
- 4 Anderson W, O'Connor BB, MacGregor RR, Schwartz JS. Patient use and assessment of conventional and alternative therapies for HIV infection and AIDS. *AIDS* 1993;7:561-5.

## Antibodies to phospholipid in alcoholic liver disease

EDITOR,—F Violi and colleagues report that a third of patients with cirrhosis of the liver had circulating antibodies to phospholipid (cardiolipin antibodies and lupus anticoagulant) and that the presence of antibodies to phospholipid is associated with an increased prevalence of splanchnic venous thrombosis.<sup>1</sup> Some of their patients had alcoholic cirrhosis, which is associated with a high frequency of non-organ specific autoantibodies.<sup>2</sup> The incidence of splanchnic venous thrombosis in chronic liver disease is less clear but is roughly 0.6-20%.<sup>3,4</sup> We have evaluated a series of patients with a range of alcoholic liver disease but without splanchnic venous thrombosis (as determined by Doppler ultrasound scanning) for the presence of antibodies to phospholipid.

Thirty patients admitted for investigation of liver disease during 1991-2 were tested for IgG and IgM antibodies to phospholipid with a commercial enzyme linked immunosorbent assay (ELISA; Cambridge Life Sciences, Cambridge, United Kingdom). All the patients had a history of alcohol

*Presence of antibodies to phospholipid, categorised by immunoglobulin type, in patients with alcoholic liver disease. Figures are numbers (percentages)*

	IgG	IgM	All antibodies
Alcoholic hepatitis (n=14)	3	3	3 (21)
Alcoholic hepatitis with cirrhosis (n=10)	5	5	6 (60)
Inactive cirrhosis (n=6)	0	0	0

misuse. Serological testing for hepatitis viruses yielded negative results, and liver biopsy specimens were characteristic of those seen in alcoholic liver disease. The table shows our findings. We conclude that antibodies to phospholipid are common in alcoholic liver disease and are not restricted to patients with cirrhosis; they also arise in patients with alcoholic hepatitis without an underlying cirrhosis.

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- 1 Violi F, Ferro D, Basili S, D'Angelo A, Mazzola G, Quintarelli C, et al. Relation between lupus anticoagulant and splanchnic venous thrombosis in cirrhosis of the liver. *BMJ* 1994;309:239-40. (23 July.)
- 2 Bailey RJ, Krasner N, Eddleson ALWF, Williams R, Tee DEH, Doniach D, et al. Histocompatibility antigens, autoantibodies, and immunoglobulins in alcoholic liver disease. *BMJ* 1976;iii:727-9.
- 3 Okuda K, Ohnishi K, Kimura K, Matsutani S, Sumida M, Goto N, et al. Incidence of portal vein thrombosis in liver cirrhosis: an angiographic study in 708 patients. *Gastroenterology* 1985;89:279-86.
- 4 Oko K, Tanaka K. Intravascular coagulation in autopsy cases with liver diseases. *Thromb Haemost* 1979;42:564-70.

## Measles and rubella immunisation campaign

### Older children should be included

EDITOR,—Do others share my reservations about the national measles and rubella immunisation campaign?<sup>1</sup> It is based on a model dear to the hearts of some people who have influence in and around the Joint Committee on Vaccination and Immunisation and draws on campaigns for one off "catch ups" in the Caribbean and in Latin America.<sup>2</sup> Such campaigns are not necessarily transferable to Britain.

Previously the Joint Committee on Vaccination and Immunisation stated that there were cohorts of increasing age still susceptible to measles and recommended that they should be offered measles, mumps, and rubella vaccine if they had not had it before.<sup>3</sup> It is with these cohorts that the real problem for future years lies (figure). Measles is more severe in older teenagers and young adults, and the American experience of outbreaks in colleges and universities would inevitably be repeated in Britain.<sup>4</sup> Health authorities, such as Argyll and Clyde Health Board, that followed those recommendations, however, got no financial help and are now likely to be penalised through having to deal with parents' and health professionals' confusion and frustration over the recommendation that children should be immunised with the measles and rubella vaccine even if they have previously been immunised with measles, mumps, and rubella vaccine.